



Medicine Man, by Henrietta M. Snowden, watercolor/colored pencil on paper, 2001.
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Chapter 8

UPDATES ON DISABILITY PROCEEDINGS

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INTRODUCTION

Some active duty members of the Department of Defense (DoD) will inevitably become ill or be wounded or injured during their service. Title 10 of the US Code Chapter 61 §§ 1021-1222 outlines the basis for the DoD disability evaluation system.¹ The DoD provides additional directives and instructions that are implemented through service-specific regulations by each service branch: the Army, the Air Force, and the naval services (Navy and Marine Corps). The goal of the disability evaluation system is to provide for a physically fit and combat-ready military, as well as to balance the interests of the government and individual service members.

A service member is deemed to be unfit due to a medical condition if the condition interferes with the ability to perform the duties of his or her office, grade, rank, or rating. Historically, each branch of service was responsible for not only determining whether or not its members were unfit due to a given medical

condition, but also for providing a percentage rating for the unfitting condition. Once the service member was discharged from active duty, he or she began the evaluation process through the US Department of Veterans Affairs (VA), which often resulted in gaps in care during the transition between the two systems. This process has been phased out recently with the implementation of the Integrated Disability Evaluation System (IDES), which provides for near-simultaneous processing of a service member through the DoD and VA systems. As a consequence of this integrated system, the responsibility for determining fitness remains with the DoD, but the VA assumes the responsibility for determining percentage rating for unfitting conditions. The goal of this new system is to maximize the probability that care of the service members will be transitioned seamlessly between the DoD and VA healthcare systems, as well as avoiding the duplication of tasks.

PROVISIONS FOR TEMPORARY LIMITATION IN SCOPE OF ACTIVITY

Before service members are referred to the IDES, the DoD medical systems make every effort to provide treatment for their medical condition with the goal of making it possible to return to the unrestricted performance of their office, grade, rank, or rating. During this time, the service member's duties may be restricted or proscribed in some way to allow him or her to undergo all treatment options.

Case Study 8-1: A soldier developed depressed mood, insomnia, difficulty with concentration, and decreased motivation in the context of in-theater stressors as well as ongoing marital discord. After receiving a letter from his estranged wife, he developed suicidal ideation with a plan to shoot himself. After disclosing his suicidal ideation to a concerned friend, the friend brought him in for medical evaluation. He was returned to the continental United States via the medical evacuation process, and arrived at Walter Reed National Military Medical Center in Bethesda, Maryland, for continued treatment.

The Army (Army Regulation [AR] 40-501/Department of the Army Form 3349)² and the Air Force (Air Force Instruction [AFI] 48-123/AF Forms 422 and 469)³ use a profiling system to classify an individual's level of functional ability and specify duty limitations. Functional ability is assessed in six different categories, referred to as factors by the Army:

1. physical condition or capacity;
2. upper extremities;
3. lower extremities;

4. hearing and ears;
5. eyes; and
6. psychiatric.^{2,3}

Each of these factors, abbreviated respectively as P, U, L, H, E, and S, is rated on a scale of functional impairment ranging from 1 to 4. This is sometimes referred to as PULHES. A rating of 1 indicates normal functioning or a high level of medical fitness; a service member with an S1 rating manifests no psychiatric pathology and is considered highly functional from a mental health perspective.^{2,3} A rating of 2 indicates that a condition is present and that some minor activity limitations may be necessary to minimize effects of the impairment.^{2,3} Adjustment disorders typically fall within this category. A rating of 3 indicates that the service member's condition affects his or her function to the extent that significant limitations on the service member's scope of duties is required to prevent him or her from adversely affecting the mission.^{2,3} Post-traumatic stress disorder (PTSD) often leads to this rating. A rating of 4 indicates the presence of a severe condition that drastically limits the service member's capacity to perform duties in a safe and effective manner.^{2,3} Schizophrenia warrants this rating.

If a soldier is expected to recover sufficiently from a condition and resume the full scope of his or her duties, a temporary profile is initiated using Department of the Army Form 3349. Each of the six factors is rated appropriately, and the service member's functional

limitations are documented. Temporary profiles are limited to 3 months, but subsequent profiles are permitted if the condition continues to significantly limit the soldier's functioning.²

The US Air Force (USAF) records functional ability for each of the six factors on AF Form 422; this information is maintained for all active duty USAF members. When significant functional limitations exist secondary to one of these factors, AFI 48-123 specifies that the impact of the service member's condition on his or her ability to perform military service must be documented on AF Form 469.³

Once a soldier's or airman's condition has stabilized and further recovery is predictable, and it becomes apparent that he or she will not return to the full scope of duty performance within 1 year of the initial diagnosis, the service member has reached a medical retention determination point.² If the service member does not meet medical retention standards, he or she is referred to a medical evaluation board (MEB).

According to the Secretary of the Navy Instruction (SECNAVINST) 1850.4E,⁴ the Navy and Marine Corps permit removal of a service member from full military duty for up to 30 days of light duty to evaluate or treat a medical condition. If the service member is unable to resume full duty performance at the end of that time, a period of temporary limited duty—more commonly referred to as limited duty (LIMDU)—may be initiated if the prognosis indicates that the service member can be restored to a full duty status within 12 months.

Sailors and Marines are placed on LIMDU using the abbreviated medical evaluation board report

(NAVMED 6100/5). This form specifies the service member's diagnosis (or diagnoses) being treated during the LIMDU period, and the limitations on the service member's functioning are listed. Generally, up to 6 months of LIMDU may be requested, and the service member's condition is reassessed 2 months before the expiration of the LIMDU period; if the treating provider determines that the service member will not return to full duty after the initial LIMDU period, another 6 months may be requested by completing another abbreviated report. Third and subsequent periods of LIMDU are generally not approved except in unusual cases, and the chief of the Medical Corps must approve them.

If, after exhausting the LIMDU time, the service member continues to have significant limitations in duty performance, he or she is referred to an MEB. It is not necessary to exhaust a service member's available LIMDU before referring the person for an MEB if it is clear at an earlier point that he or she will not be sufficiently recovered, even after using the maximum possible LIMDU available.

Case Study 8-1 (continued): The soldier was hospitalized for several days in the Walter Reed National Military Medical Center's inpatient psychiatry service and started on Zoloft (Pfizer Pharmaceuticals, New York, NY). Following discharge, he followed up as an outpatient for medication management and weekly psychotherapy. Several weeks after titrating the medication to 100 mg daily, his symptoms improved and eventually resolved. Asymptomatic at month 4, he completed LIMDU and returned to full duty at the end of his treatment.

SEPARATION OR RETIREMENT FOR PHYSICAL DISABILITY

Referral to Integrated Disability Evaluation System

Case Study 8-2: Police apprehended a sailor (stationed aboard a ship home ported at Naval Base Norfolk) for driving 115 miles per hour in a 55 mile per hour zone. She was agitated and paranoid, and was taken to the nearest department for further evaluation. Medical evaluation did not reveal any drug or alcohol intoxication or other organic cause for the sailor's behavior, and she was transferred to the inpatient psychiatry service at Naval Medical Center Portsmouth for further evaluation.

Medical treatment while on a temporary profile or during LIMDU is often sufficient to allow the service member to resume unrestricted performance of his or her office, grade, rank, or rating. But in many cases, a service member is unable to do so after the allotted time for a temporary profile or LIMDU is exhausted, or it becomes apparent to the service member's provider that he or she will not return to duty even after exhausting all available profile or LIMDU time.

Case Study 8-2 (continued): While on the ward, the sailor revealed that she had devised a plan to solve the world's energy supply issues, and as a result, she had been targeted for assassination. Due to her concern about her personal safety, she refused to eat or take medications that she suspected were poisoned. She was eventually placed on elopement precautions after hospital staff members were incorporated into her delusion. After several weeks of hospitalization, she agreed to take medication, but discontinued it after several days because it made her feel sluggish. She withdrew her consent to hospitalization and remained on the ward in an involuntary status for several weeks.

In the event that the service member's treating provider determines that he or she continues to manifest a condition that significantly interferes with reasonable duty performance or a condition that may compromise the health or well-being of the individual (or other service members) if he or she were to be retained in the military service, the provider may refer the service

member to the IDES. This referral begins a cascade of evaluations that provides for a fitness assessment.

IDES referral is initiated with a one-page form (VA Form 21-0819) documenting the condition that, in the provider's opinion, limits the service member's duty performance; this is considered to be the "referred" condition. The provider may list multiple referred conditions on this form. The service member also has the opportunity to list additional medical conditions that affect his or her functioning; these are known as "claimed" conditions.

Typical Causes for Referral to the Physical Evaluation Board

Diagnosis of a particular condition does not mean that a service member is rendered unfit or that retirement or separation from active duty is automatic. However, according to SECNAVINST 1850.4E (attachment 8),⁴ conditions are appropriate for referral to the physical evaluation board (PEB) and are potentially unfitting if they:

- "significantly interfere with the reasonable fulfillment of the purpose of the individual's employment in the military service;
- may seriously compromise the health or well-being of the individual if he or she were to remain in the military service. This may involve dependence on certain medications, appliances, severe dietary restrictions, or frequent special treatments, or a requirement for frequent clinical monitoring; and
- may prejudice the best interests of the Government if the individual were to remain in the military service."⁴

Similar guidance is contained in AR 40-501, chapter 3² and AFI 48-123, chapter 5.³

SECNAVINST 1850.4E⁴ and AR 40-501² similarly delineate the types of disorders that warrant referral to the PEB as potentially unfitting conditions:

- disorders with psychotic features;
- affective (mood) disorders;
- anxiety, somatoform, and dissociative disorders;
- organic mental disorders, including dementia and cognitive disorders; and
- eating disorders.

In addition to having the diagnosis, the symptoms of the diagnosis must interfere with the service member's performance of duties and require ongoing treatment. AFI 48-123³ specifically discusses psychotic,

mood, and anxiety disorders, but the instruction is written in a way to permit referral for the conditions mentioned by the documents discussed above.

All three instructions²⁻⁴ also specifically discuss psychiatric conditions that do not constitute a physical disability; instead of rendering a service member physically unable to perform duties, he or she would be considered administratively unsuitable. Conditions belonging to this category include the following:

- personality disorders;
- sexual disorders, including paraphilias;
- factitious disorders;
- certain disorders of impulse control;
- adjustment disorders (except chronic adjustment disorders);
- substance-related disorders;
- mental retardation, learning disorders, and attention deficit hyperactivity disorder; and
- disorders of childhood development.

Case Study 8-3: An airman was brought to the emergency department after an impulsive suicide attempt. He reported that he felt angry and abandoned after his wife sent him a text the previous evening stating that she was leaving town and wanted a divorce. He acknowledged a lifelong pattern of anger dyscontrol, fears of abandonment, impulsivity, and intermittent suicidal ideation. He reported numerous chaotic romantic relationships, but added "the crazy ones always find me." After a brief hospitalization, his mood improved and he divorced his wife and resumed a previous romantic relationship. Based on his history he was diagnosed with borderline personality disorder; his pattern of alcohol use also warranted diagnosis of alcohol dependence. He was sent to an inpatient rehabilitation program for alcohol dependence, but his continued impulsivity and anger dyscontrol issues resulted in eventual administrative separation.

Medical Evaluation Board

The MEB is written once a service member's limited duty time is exhausted and it is determined that his or her condition will likely preclude a return to unrestricted full duty, or that a permanent profile is necessary. The medical evaluation board report (MEBR) or narrative is prepared by a panel of physicians to document the service member's medical condition. The MEBR must:

- confirm the medical diagnosis;
- document treatment course, current medical status, and prognosis (including potential for medical recovery); and
- pinpoint the onset of condition (whether or not it was before service), and whether the condition has been permanently aggravated by the service member's service.

Receiving a specific diagnosis does not—in and of itself—indicate that the service member is unfit; rather, a finding of unfit is based on the limitations placed on the service member's functioning as a result of the diagnosis.

Nonmedical Assessment

Although the MEBR contains valuable clinical information about the service member's functional limitations resulting from a medical condition, assessment by the chain of command may be more helpful in determining his or her ability to perform assigned duties. SECNAVINST 1830.4E⁴ outlines the requirements for the nonmedical assessment required for all cases referred to the Navy PEB:

- observations of the service member's medical condition (or lack thereof) in on-duty and off-duty situations;
- description of current assignment and a statement of how the condition has affected performance (including ability to deploy);
- description of the service member's rating or military occupational specialty and an estimation of how the service member's condition may affect his or her ability to fulfill future occupational requirements; and
- identification of any pending legal or disciplinary actions.⁴

When the service member has been reassigned to a military medical treatment facility (MTF) for treatment purposes, the nonmedical assessment should be obtained from the service member's previous unit commander, but it is often completed by the MTF. These MTF-completed evaluations are often suboptimal because of the lack of subject matter expertise on the part of MTF administrators regarding the specific duties of their patients.

AR 635-40⁵ also requires a statement from the soldier's commander. The statement must address whether any adverse personnel action is being considered against the service member; it must also address the service member's current ability to perform his or her duties and any limitations resulting from his or her condition.

AFI 36-3212⁶ requires a written statement from the service member's immediate commanding officer describing his or her medical condition and the condition's impact on the service member's typical duties and ability to deploy or mobilize.

Veterans Affairs Compensation and Pension Examination

Once the service member is referred to the IDES, the physical evaluation board liaison officer and the VA military services coordinator at the service member's

MTF begin the development of the IDES case file. The physical evaluation board liaison officer works with medical specialists involved in the service member's care to determine which conditions will be included in the MEBR. The military services coordinator assists with completion of VA documents and schedules the VA medical examinations the service member requires. These VA evaluations are called the compensation and pension (C&P) examinations. These examinations are made available to the service member's provider for review and integration into the MEBR. These C&P examinations are also the basis for the disability rating assigned to the service member's unfitting conditions: each condition identified on a VA C&P examination receives a percentage rating. If the service member is found unfit during the PEB process, this list of ratings furnishes the rating percentage for each unfitting condition.

For the vast majority of IDES cases, the C&P examination findings are congruent with the evaluation and diagnosis documented in the MEBR. However, in a small minority of cases the C&P findings deviate from those of the MEBR.

Case Study 8-4: A soldier was diagnosed with major depressive disorder following a suicide attempt. Treatment with antidepressant medication and psychotherapy did not resolve the symptoms, and the soldier continued to have difficulty with performing his job. He was referred to the IDES, and was diagnosed with acute adjustment disorder with depressed mood by the C&P psychiatrist.

The MEBR physician has the opportunity to review the results of the C&P examination, which provide him or her with an opportunity to address any discrepancies. It is essential that the MEBR physician comment on the discrepancies and attempt to account for them; not doing so may delay IDES processing while the PEB members attempt to resolve the conflicting information.

Case Study 8-4 (continued): The psychiatrist writing the MEBR, who had treated the service member for several months before IDES referral, reviewed the C&P examination and noted that the entire focus of the interview was the soldier's recent separation from his wife. In the MEBR, the psychiatrist noted that the service member's depressive symptoms were pervasive and predated the separation. He also specified how the service member met the diagnostic criteria for major depressive disorder.

The MEBR physician may, after reviewing the C&P examination, conclude that one or more of the service member's claimed conditions may be unfitting. Such a situation warrants further evaluation, and the MEBR physician may refer the service member for a MEBR addendum addressing the additional condition or conditions.

Additional Documents

When a service member is on active duty, injuries or illnesses that occur are generally presumed to have been incurred “in the line of duty.” However, injuries are not considered to have occurred in the line of duty under certain conditions, such as:

- if they resulted from a service member’s misconduct;
- if they occurred while the service member was in an unauthorized absence or deserter status; or
- if they occurred during confinement under sentence of a courts-martial or a civil court following felony conviction.

Conditions that were incurred not in the line of duty and as the result of a service member’s misconduct are not eligible for disability benefits. This disqualification only applies to conditions considered to be not in the line of duty; if the service member has additional conditions that are considered to be in the line of duty, the service member remains eligible for disability benefits for these conditions.

A service member may submit a statement as part of the case file forwarded to IDES. The service member may elect to submit a rebuttal to the MEBR if he or she disagrees with any aspects of the evaluation. Service members may dispute facts contained in the history, the diagnoses made, or the degree of functional impairment resulting from these conditions. If a service member submits a MEBR rebuttal, a response is required

from the MEBR physician specifically addressing the issues raised by the service member in the rebuttal; this is called a surrebuttal.

The service member may also submit a stand-alone statement for various reasons. Some of the most common describe the circumstances of the service member’s injury, which often happens when an injury warrants a line of duty investigation. Service members may also simply submit an addendum directly to the PEB members to describe the condition and degree of disability; occasionally, these statements make the case that the disease or condition does not affect the service member’s ability to perform duties and request a finding of fitness.

MTF and civilian treatment notes constitute the physical bulk of the IDES case file. The entirety of the service member’s military medical record, including Armed Forces Health Longitudinal Technology Application records, relevant Composite Health Care System results, and all available treatment notes from civilian facilities are included. These records serve several purposes and provide additional information about the service member’s condition that may be missing in the MEBR or C&P documentation. They may also assist in resolving discrepancies between the MEBR and C&P evaluations. One of the most valuable functions of this documentation is the information such records provide about the longitudinal evolution of the service member’s condition. Using these records, which document the service member’s progression across months (or even years), a more complete picture of the service member’s disability (or lack thereof) can be developed.

REFERRAL TO THE PHYSICAL EVALUATION BOARD

Informal Physical Evaluation Board

Once the MTF physical evaluation board liaison officer compiles the MEBR, nonmedical assessment, VA C&P examination, and additional documents, the resulting case file is sent to the PEB. The PEB, composed of a panel of three service members—two line officers and one medical officer—informally adjudicates the case. The following determinations are made:

- a determination of fitness for each condition;
- for each unfitting condition, a determination of whether the condition existed before service (and if so, whether the condition was permanently service aggravated);
- for each unfitting condition, an opinion on combat relatedness; and

- a finding on whether each unfitting condition is considered to be permanent.

Several factors are considered when making determinations of fitness: whether the condition impairs the service member’s ability to perform key aspects of his or her duties; whether retention of the service member poses a danger to the service member or to fellow service members; and whether accommodation of the service member on active duty poses an unreasonable burden to his or her command.

Case Study 8-5: A Marine rifleman sustained a severe left lower extremity injury when his vehicle detonated an improvised explosive device and caught fire. He was able to exit the vehicle and rescue another Marine, a field radio operator, who was unconscious. He was unable to rescue the driver before flames overcame the vehicle. He returned to the continental United States and received treatment for

his injury, but his physicians were unable to salvage his leg, resulting in a below-the-knee amputation (BKA). While recovering from this injury, he began treatment for anxiety symptoms and was eventually diagnosed with PTSD. He was eventually referred to the IDES for the left BKA and PTSD, and he was also diagnosed with alcohol dependence.

Case Study 8-6: The field radio operator lost consciousness for approximately 10 minutes following the blast. When he regained consciousness, he complained of headache and dizziness. He was held back on base for several weeks, but continued to complain of migraine headaches, dizziness, and memory problems. He returned to the continental United States and was treated for traumatic brain injury. Upon completion of his rehabilitation, almost all of his symptoms had resolved except for the migraine headaches and cognitive problems; he was referred to the IDES for posttraumatic headaches and cognitive disorder, not otherwise specified.

Categorization of Findings

If a service member is found unfit by the PEB for any condition, all the referred conditions are placed into one of four categories:

- category I: unfitting conditions;
- category II: conditions that contribute to an unfitting condition, but are not separately unfitting on their own; each of these conditions is associated with the corresponding category I condition;
- category III: conditions that are not separately unfitting, and do not contribute to any category I unfitting conditions; and
- category IV: conditions that do not constitute a physical disability.

Case Study 8-5 (continued): The rifleman was found unfit (category I) for his left BKA. Due to the mild symptoms documented in the MEBR and a nonmedical assessment that did not document any dysfunction from anxiety symptoms, PTSD was determined not to be separately unfitting, nor was it related to another unfitting condition (category III). Alcohol dependence was considered to be a condition not constituting a disability (category IV).

Case Study 8-6 (continued): The field radio operator was found unfit for his headaches (category I). Although the cognitive disorder contributed to the service member's difficulty with focus and concentration when he was symptomatic from the headaches, it did not substantially affect his ability to perform his duties otherwise; it was determined to be category II.

If the service member is found fit for all conditions, the findings are sent to the service member without returning them to the VA for rating. If the service

member has been found unfit for any condition, the finding is sent to the VA for assignment of a rating scheme, returned to the PEB for finalization, and sent to the service member.

Case Study 8-7: An Air Force major had a history of mild ulcerative colitis for approximately 10 years. After her most recent minor flare up, her gastroenterologist referred her to the IDES system. The service member demonstrated that she was able to perform all her duties, and her treatment regimen did not preclude her ability to deploy or be stationed in remote locations. The PEB determined she was fit and she continued her career.

If the service member accepts his or her findings, or does not respond within a specified time, the case is finalized and the service member is not entitled to a formal PEB. If he or she does not accept, the case is referred to a formal PEB. In the meantime, the service member may submit an informal reconsideration if additional information relevant to the case may result in a decision different from the informal PEB's initial findings.

Formal Physical Evaluation Board

The formal PEB, as opposed to the informal PEB described above, is a de novo hearing intended to make findings concerning a service member's fitness for continued service and eligibility for disability benefits. It is composed of three senior military officers: two line officers and one medical officer. The line officers are chosen based on the breadth of their military experience. The medical officer, who may have a particular specialty, has the experience to adjudicate cases across the medical spectrum. The board is nonadversarial and formal rules of evidence do not apply. In addition, the service member may present additional material as well as testimony that supports his or her case.

As soon as the case is scheduled for a formal board, the service member is assigned military counsel to prepare the case. The service member may choose his or her counsel, including representation by a nonlawyer, but this representation is at his or her expense. In this case, the service member's assigned military counsel may act as associate counsel if requested. Counsel advises the service member of all the case's substantive legal considerations and assists with presenting his or her argument at the formal board. As part of this presentation, witnesses and other evidence may be presented. This other evidence includes the case file developed during the informal board proceedings, new medical evidence, and new nonmedical evidence. The service member has the right not only to appear personally at the formal board either by telephone or

teleconference if he or she cannot travel, but also to offer testimony through oral or written statements (but may elect not to do either). At the end of the formal board, counsel also assists the service member by advising him or her on available options once the board's findings are received.

During the formal board proceeding, counsel presents the service member's argument, with the assistance of his or her sworn testimony, if he or she desires to testify. Witnesses, if present, also present sworn testimony. PEB members may question service members and witnesses testifying in a formal board to further clarify pertinent issues that have been raised by information in the case file as well as testimony gathered during the formal board. Once counsel has presented the case, he or she makes a closing statement, and then the service member can make any additional statements. After the formal board ends, the board members make a decision based on a vote of the

board members. The service member receives a written rationale documenting the reasoning underlying the decision, which is generally unanimous; in the case of a majority decision with a dissenting vote, the rationale for the decision is accompanied by a minority rationale. If the service member disagrees with the formal board findings, he or she may submit a petition for relief. Procedures for submitting a petition vary by service.

Case Study 8-5 (continued): The rifleman presented additional, more recent treatment notes demonstrating the ongoing presence of severe anxiety symptoms that were not responding to an intensive medication and psychotherapy regimen. Additionally, the service member's testimony made it clear that the nonmedical assessment, which was written by the MTF medical holding company, did not reflect the impact the service member's symptoms would have on duty performance. After the formal board ended, its members found that the rifleman was unfit for the left BKA as well as PTSD.

SPECIAL SITUATIONS AFFECTING REFERRALS TO THE PHYSICAL EVALUATION BOARD

Conditions Existing Before Active Military Service

Some conditions for which service members are referred to the PEB may have existed or initially manifested before their military service. These conditions are considered to have existed prior to service and are ratable or grounds for disability benefits. If the condition worsens during the service member's time in service, the PEB must determine whether military service aggravated it; and if it did, then the service member would receive disability benefits commensurate with the degree of deterioration in his or her existed prior to service condition. Service aggravation is presumed unless the condition worsening is attributed to the illness's "natural progression." The Navy mandates clear and unmistakable evidence to rebut the presumption of service aggravation.

Line of Duty Determination

Illness or injury incurred while in active service, which includes inactive duty training, is generally presumed to have been incurred in the line of duty; the service member is therefore eligible to receive benefits for the relevant condition if he or she is found unfit. Conditions incurred during an unauthorized absence are not considered to be in the line of duty, nor are conditions resulting from intentional misconduct or willful neglect. In IDES cases where the referred condition was the consequence of an incident that raises questions about misconduct as a relevant factor, a line of duty investigation is required of the service mem-

ber's command. If the condition is demonstrated to not be in the line of duty, the service member is ineligible for IDES referral on the basis of that condition. Clear and convincing evidence of intentional misconduct or willful neglect is required to overcome the presumption that the condition was incurred in the line of duty.

According to SECNAVINST 1850.4E,⁴ ordinary negligence or carelessness is insufficient to indicate misconduct. The service member's conduct must have been intentional or the "proximate result of such gross negligence as to demonstrate a reckless disregard of the consequences."⁴ If the condition in question could have been "reasonably foreseen" as the consequence of a service member's conduct, it is considered to be a proximate result.⁴

Case Study 8-8a: A Marine lance corporal was returning from leave when he fell off his motorcycle while excessively speeding around a curve on a highway. There was no inclement weather, and no other vehicles were on the road. He was taken to the hospital with several significant orthopedic injuries. His blood alcohol level upon arrival at the hospital was 0.275%. After extensive rehabilitation, his persistent right knee pain and instability precluded him from performing in his military occupational specialty.

This service member's right knee condition did not occur in the line of duty, but rather from his own misconduct. It is considered reasonable to foresee that consuming a sufficient amount of alcohol to cause a blood alcohol level of 0.275% and traveling at an excessive rate of speed can result in injury. If found to be unfitting, the condition is not rated, and the service

member is not eligible for benefits for this specific disability. If the service member was considered to be in the line of duty for a separate condition, however, his eligibility for benefits under this second condition remains intact.

Case Study 8-8b: Another Marine lance corporal was stopped at a red light when a minivan, whose driver did not see the stoplight, hit him from behind at a high rate of speed. The Marine's blood alcohol level was found to be 0.275% after arrival at the hospital. Although the Marine engaged in inappropriate conduct by operating his motorcycle while intoxicated, he could not have foreseen the behavior of the minivan driver, and thus his injury was not the proximate result of his conduct.

When required, line of duty determinations are made by the service member's command and submitted to the PEB. The PEB has limited ability to deviate from these findings, depending on the service.

Presumption of Fitness

Disability benefits are intended to provide compensation for the premature termination of a service member's career resulting from an unfitting condition. When a service member has been able to perform his

or her duties and is within 12 months of retirement, a presumption of fitness exists that may be overcome in one of three ways:

1. An acute and grave illness or injury occurs, and this condition would prevent the service member from performing further duty if he or she were not retiring; or
2. A serious deterioration of a previously diagnosed condition has occurred, and the worsened condition would prevent the service member from performing further duty if he or she were not retiring; or
3. The condition is chronic and, based on a preponderance of the evidence, the service member had not been performing duties appropriate to his or her office, grade, rank, or rating before entering the presumptive period (12 months before retirement).⁴

Service members found to be presumptively fit remain on active duty until reaching their retirement date; service members who overcome the presumption of fitness are processed in the same way as any other individual with an unfitting condition.

CASE FINALIZATION AND SEPARATION FROM ACTIVE DUTY SERVICE

Once the PEB finalizes its findings, each unfitting condition is assigned a VA code and corresponding percentage disability rating based on the VA disability rating percentages derived from the C&P examination. The percentage rating, or combination of ratings, is used to determine whether the service member will be placed on the temporary disability retirement list (TDRL) or separated with severance pay. If a service member's total disability rating is 30% or higher, he or she is placed on the TDRL. The board also has the option to place a service member on the permanent

disability retirement list if it is clear that his or her condition or conditions are sufficiently stable so that the disability rating will not substantially change.

Case Study 8-5 (continued): The rifleman was rated 40% under VA code 5165 for the left BKA and 70% under VA code 9411 for PTSD, for a combined rating of 82%, which rounds to 80%. He was placed on the TDRL.

Case Study 8-6 (continued): The field radio operator was rated 10% under VA code 8100 for his headaches. He was separated with severance pay.

POSTRETIREMENT

Service members placed on the TDRL require periodic reevaluation approximately every 18 months to determine the status of their condition. These evaluations are typically conducted at an MTF; other facilities may conduct TDRL evaluations, but the designated responsible MTF must ensure that the report is complete and adequate. The service member receives written orders to report to the MTF for the examination.

The TDRL evaluation documents the interval history since the service member's last examination, including the course of the condition, the treatment,

and his or her current condition. Pertinent objective information, including a mental status examination and relevant laboratory or other tests, is included as necessary. Generally, a physical examination is not part of a TDRL evaluation for a mental health condition. The examiner is also asked to render an opinion on the service member's impairments with respect to industrial and social adaptability, the stability of the condition, and the service member's prognosis.

The case is then sent back to the PEB for a review. The PEB has several options based on what has hap-

pened since the last evaluation. If the service member's condition has still not stabilized sufficiently for rating, the service member may be retained on the TDRL and reexamined in another 18 months; the rating remains unchanged. If the service member's condition has stabilized, the case may be finalized. The rating may be adjusted at finalization depending on the change in the service member's condition; if the rating remains more than 30%, the service member is placed on the permanent disability retirement list; if it is less than 30%, the service member is separated. The third option is that the service member is found fit to return to active duty. Service members cannot remain on the TDRL for more than 5 years.

In certain circumstances, a service member's rating may be changed before TDRL finalization. The Code of Federal Regulations Title 38, Chapter 1, Part 4, § 4.129 states that:

When a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination

within the six month period following the veteran's discharge to determine whether a change in evaluation is warranted.⁷

These service members are brought back to their first TDRL evaluation within the 6-month period and the percentage rating for their condition is adjusted as appropriate. It remains at this adjusted level until the case is finalized and the service member is taken off of the TDRL.

Case Study 8-5 (continued): The rifleman began to make significant progress in his PTSD treatment shortly after retirement and was significantly less symptomatic at his 6-month TDRL evaluation. On the basis of the TDRL evaluation, he was rerated at 30% under VA code 9411 for PTSD (40% under VA code 5165 for the left BKA remained unchanged) for a combined rating of 58%, which rounds to 60%. He continued on the TDRL.

One important difference between the initial rating process and subsequent rerating is that the VA only does the initial disability rating; the service-specific PEB does all of the rating adjustments made after a service member is placed on the TDRL.

SUMMARY

The IDES implemented across the DoD military branches serves to preserve a fit fighting force while providing for the care of service members who have suffered illness or injury in the line of duty. Recent changes, most notably the near-simultaneous processing of a service member's case through the DoD and

VA medical systems, have been implemented with the intent to improve transitioning veterans between the two organizations. Although this change initially prolonged the IDES processing time, it has served to ensure that a service member is introduced to the VA system by the time he or she is separated from active duty service.

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7. 38 CFR, Chapter 1, Part 4, § 4.129, *Mental Disorders due to Traumatic Stress*.